| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155580 | A. BUILDING _____ B. WING _____ | R-C 04/17/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TIMBERVIEW HEALTH CARE CENTER | 2350 TAFT ST GARY, IN 46404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS<br><br>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00122956 and IN00123512 completed on February 4, 2013.<br><br>This visit was in conjunction with the Investigation of Complaints IN00123856, IN00124904, IN00125426, IN00126490, and IN00126855.<br><br>Complaint IN00122956- Corrected.<br><br>Complaint IN00123512- Corrected.<br><br>Survey dates:<br>April 14, 15, 16, & 17, 2013<br><br>Facility number: 008505<br>Provider number: 155580<br>AIM number: 200064830<br><br>Survey team:<br>Janet Adams, RN, TC<br><br>Census bed type:<br>SNF: 7<br>SNF/NF: 122<br>Total: 129<br><br>Census payor type:<br>Medicare: 15<br>Medicaid: 107<br>Other: 7<br>Total: 129<br><br>Sample: 16<br><br>Timberview Health Care Center was found to be in compliance with 42 CFR Part 483, Subpart B | {F 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| TIMBERVIEW HEALTH CARE CENTER | 2350 TAFT ST GARY, IN 46404 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| {F 000} | Continued From page 1<br>and 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the Investigation of Complaints IN00122956 and IN00123512.<br><br>Quality review completed on April 18, 2013, by Janelyn Kulik, RN. | {F 000} | | |